District Council 16 Health and Welfare Enrollment Booklet

ENROLLMENT INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE ATTACHED ENROLLMENT FORMS. In order to enroll yourself and your eligible dependents into the District Council 16 Northern California Health & Welfare Plan, you must complete all of the required Enrollment Forms included in this Enrollment Booklet. **Be sure to completely and accurately provide all of the required information requested on the Enrollment Forms, *enrollment will not be granted without proper documentation.**

Use the enclosed envelope to mail your completed booklet to the Fund Office. The address for the Fund Office is: District Council 16 Health and Welfare Trust Fund **4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756. Or email:** dc16info@hsba.com

***TO NEWLY ENROLL OR CHANGE A DEPENDENT, THE FOLLOWING DOCUMENTS ARE REQUIRED AND MUST BE SUBMITTED WITH YOUR ENROLLMENT FORMS:**

- COPIES OF MARRIAGE OR DIVORCE CERTIFICATES
- DOMESTIC PARTNERSHIP AFFIDAVIT AND VERIFICATION OF DOMESTIC PARTNER REGISTRATION FROM THE GOVERNMENT BODY AUTHORIZED TO PROCESS SUCH REGISTRATION
- COPIES OF BIRTH CERTIFICATES FOR DEPENDENT CHILDREN (DUE within 60 days of birth date)
- FOSTER & ADOPTED CHILDREN: THE COURT DOCUMENTS GRANTING GUARDIANSHIP OR ADOPTION

DEPENDENT ELIGIBILITY AND ENROLLMENT – WHO IS ELIGIBLE:
When you qualify for benefits, the following dependents may also be covered:

- **Your Legal spouse or registered domestic partner**
- **Children who are less than 26 years of age:**
  - Natural children (Provide Birth Certificate within 60 days of birth date)
  - Step-children who reside with you and are dependent on you for support & their primary parent
  - Legally adopted children and foster children
  - Children for whom you have been appointed legal guardian

Please refer to the SPD for complete dependent eligibility qualifications and rules.
Parents of Participants are NOT eligible for participation in this Health Plan

Trust Fund Website: For additional information please visit **https://www.dc16trustfund.org** where you will find ONLINE access to all Health and Welfare Plan documents including this Enrollment Booklet, all Summaries of Benefits & Coverage, working Summary Plan Description, forms and useful links. You also have access to a secure portal where you can login and view real-time personalized information about your health plan benefits.

DISTRICT COUNCIL 16 NORTHERN CALIFORNIA HEALTH AND WELFARE PLAN
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756
Toll Free (800) 922-9902 * Fax: (925) 833-7301
https://www.dc16trustfund.org
dc16info@hsba.com

The Trust Fund Office is required to safeguard the privacy of all participants' individually identifiable health information as required by federal regulations. The Union and Employers cannot access member's individual health information.

DC 16 Smart Choices HEALTHY REWARDS

FUND OFFICE USE ONLY:
DATE PROCESSED: _____
PROCESSOR: _____

☐ NEW MEMBER OR CHANGE OF: ☐ NAME ☐ MARITAL STATUS ☐ PLAN ☐ BENEFICIARY ☐ DEPENDENTS ☐ NEWBORN
☐ MARRIAGE ☐ DIVORCE ☐ CHANGE OF ADDRESS OR ☐ OTHER: _____

PARTICIPANT DATA

LAST NAME	FIRST NAME	MI	DATE OF BIRTH / /
ADDRESS	CITY / STATE / ZIP / SEX		SOCIAL SECURITY # - -
EMAIL ADDRESS	TELEPHONE # ( )	CELL # ( )	Contact via text or email? Yes ☐ No ☐
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ DOMESTIC PARTNER	DATE OF MARRIAGE or DIVORCE: / /	EMPLOYER:	LOCAL UNION #:

STATUS:

☐ ACTIVE

☐ RETIREE WITHOUT MEDICARE

☐ RETIREE WITH MEDICARE

MEDICAL PLAN SELECTION – CHOOSE ONE:

☐ B.C. (PPO) *$1,000 Ded. Sutter Providers, No S.C. rewards*
☐ B.C (PPO) *$1,000 Ded. Sutter Providers *WITH S.C. rewards*
☐ B.C. (APPO) *No S.C.* rewards
☐ B.C. (APPO) **WITH S.C. rewards*
☐ KAISER (DHMO) *$1,000 Deductable*
☐ KAISER (HMO) **S.C. Rewards*

DENTAL PLAN SELECTION – CHOOSE ONE:

☐ DELTA DENTAL #0308

☐ DELTACARE #6123

☐ UNITED HEALTHCARE/PUD #712019

If you choose to opt out of the dental plan and/or vision plan benefits, there is no incentive, reward, or financial gain provided to you or your dependents.

OPT OUT OF DENTAL ☐ AND OR VISION ☐

*ADDITIONAL STEPS ARE REQUIRED TO ENROLL INTO THE SMART CHOICES REWARDS PROGRAM; FAILURE TO COMPLETE SMART CHOICES ENROLLMENT REQUIREMENTS WILL RESULT IN BEING ENROLLED IN THE CORRESPONDING TRADITIONAL PLAN.

IF YOU SELECT THE KAISER PLAN AND HAVE PREVIOUSLY BEEN COVERED BY KAISER PERMANENTE, PLEASE PROVIDE YOUR ORIGINAL KAISER MEDICAL RECORD NUMBER:

#_____

DEPENDENT DATA

Attach copy of Marriage, Domestic Partner or Birth Certificate with enrollment form

FULL NAME *Please add Dependents names below:*	RELATION	SEX	DATE OF BIRTH	SOCIAL SECURITY#	RECEIVING MEDICARE PART A OR B	KIDNEY TRANSPLANT OR DIALYSIS
SPOUSE OR DOMESTIC PARTNER:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						

PERSONAL & DEPENDENT DATA CONTINUED

COMPLETE THE SECTION BELOW AND ENCLOSE A COPY OF THE MEDICARE CARD IF YOU OR A DEPENDENT ARE ENROLLED IN MEDICARE:

PLEASE LIST THE INDIVIDUAL RECEIVING MEDICARE: _____	RECEIVING PART A: YES ☐ NO ☐ RECEIVING PART B: YES ☐ NO ☐	EFFECTIVE DATE A: _____ EFFECTIVE DATE B: _____
PLEASE LIST THE INDIVIDUAL RECEIVING MEDICARE: _____	RECEIVING PART A: YES ☐ NO ☐ RECEIVING PART B: YES ☐ NO ☐	EFFECTIVE DATE A: _____ EFFECTIVE DATE B: _____
PLEASE LIST THE INDIVIDUAL RECEIVING DIALYSIS: _____	RECEIVED KIDNEY TRANSPLANT: YES ☐ NO ☐ RECEIVING DIALYSIS: YES ☐ NO ☐	DATE OF TRANSPLANT: _____ DATE OF FIRST TREATMENT: _____

ADDITIONAL ADDRESS & INSURANCE INFORMATION

PLEASE LIST ANY DEPENDENT WITH AN ADDRESS DIFFERENT THAN THE MEMBERS ADDRESS:

DEPENDENT: _____ ADDRESS: _____CITY:_____ST:_____ZIP:_____

DEPENDENT: _____ ADDRESS: _____CITY:_____ST:_____ZIP:_____

PLEASE LIST ANY DEPENDENT WHO IS ENTITLED TO BENEFITS FROM ANOTHER GROUP HEALTH CARE, INSURANCE, OR PRE-PAID MEDICAL PLAN:

DEPENDENT: _____ ADDRESS: _____CITY:_____ST:_____ZIP:_____

DEPENDENT: _____ ADDRESS: _____CITY:_____ST:_____ZIP:_____

Kaiser Permanente Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Kaiser Permanente Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Name: _____ Signature: _____ Date: _____

YOU MUST SIGN IN ORDER TO PROCESS YOUR "KAISER" ENROLLMENT SELECTION. FAILURE TO SIGN ABOVE WILL RESULT IN BEING ENROLLED IN THE "BLUE CROSS NETWORK (PPO)"

BENEFICIARY OF DEATH BENEFIT

BENEFICIARYS FULL NAME & ADDRESS	SOCIAL SECURITY #:	DATE OF BIRTH	%:
BENEFICIARYS FULL NAME & ADDRESS	SOCIAL SECURITY #:	DATE OF BIRTH	%:
BENEFICIARYS FULL NAME & ADDRESS	SOCIAL SECURITY #:	DATE OF BIRTH	%:

YOU MUST SIGN BELOW IN ORDER TO PROCESS YOUR ENROLLMENT APPLICATION:

YOUR FULL NAME:	SIGNATURE:	DATE:
_____	_____	_____